HMIS Informed Consent and Release of Information Authorization Form

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation.
If this applies to you, STOP - Do not sign this form.

This agency participates in the Snohomish County HMIS by collecting information, over time, about the characteristics and service needs of men, women, and children experiencing homelessness or who are at-risk of homelessness.

To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Snohomish County. In order to make sure that clients are not counted twice if services are provided by more than one agency, we need to collect some personal information. Specifically, we need**: name, birth date, social security, race, and last permanent address.** Your information will be stored in our database for 7 years.

- The data you provide will be combined with data from the Department of Social and Health Services (DSHS) for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members in the research division who have signed confidentiality agreements will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Snohomish County and Washington State HMIS system administrators have full access to all information in HMIS. This includes the Dept. of Commerce staff, Seattle Safe Harbors, designated agency system administrators, and the two software vendors, ClientTrack and Adsystech.

- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to your information be supplied in HMIS in order for you to receive services from that funding source.

- We will guard this information with strict security policies to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and identity checks required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at (425) 388-3270.

I understand the above statements and consent to the inclusion of personal information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personal information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency.

Dependent children under 18 in household, if any (Please print first and last names):

_____	_____
_____	_____
_____	_____
CLIENT SIGNATURE (PARENT/GUARDIAN)	**DATE**
_____	_____
CLIENT NAME	**STAFF NAME**

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In addition to my basic personal information, I give this Agency permission to share the following types of information about me and any dependents listed below verbally, or through HMIS, mail, fax, or by hand. Please check all that apply.

- □ **Coordinated Intake and Assessment**
- □ **Housing and Services Referral (including waitlist information)**
- □ **Services received (including program enrollment(s))**

By signing this, I certify I understand that:

- The purpose of sharing this information with other agencies is to help with case management, improve the services I receive, and allow other agencies to access information about me more quickly if needed.
- I am entitled to a copy of this release and sharing form.
- I may revoke this sharing permission at any time by delivering or mailing a written statement canceling my consent and/or release of information to this Agency. Revoking my consent/release will not change anything for those people or agencies that had previously received my information while my consent/release was in effect.
- The current list of agencies who are Snohomish County HMIS Partners or MOU Partners that may have access to my information (if agreed to below) is available from this Agency. I understand that additional agencies may join the Snohomish County HMIS and will also have access to this information at that time. I understand that, upon my request, this Agency must provide me with a list of current HMIS Agencies before I sign this release and information sharing form, and must allow me to view the updated list of agencies so long as my release/sharing permission remains in effect.
- I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CRF, 160 & 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that if I give this Agency permission to share any of the above information, it will be combined with the personal information I've agreed to include in HMIS (name, date of birth, gender, etc.) so other agencies that provide me services will be able to identify who the information is about.
- I have reviewed a copy of the Snohomish County HMIS Client Privacy Rights posted at this Agency.

  □ **Option One:** Share with any other HMIS agency necessary to provide me the service I need; **OR**

  □ **Option Two:** Share with only the following agencies or specified MOU**:** _____

Note: We are not required to agree to additional restrictions that you request beyond those listed here. But, if we do agree to additional restrictions (that you request in writing), then they are binding on this Agency and on Snohomish County HMIS.

Dependent children under 18 in household, if any (Please print first and last names):

_____ _____

_____ _____

_____ _____

CLIENT SIGNATURE (PARENT/GUARDIAN) **DATE**

_____ _____

CLIENT NAME **STAFF NAME**

Unless revoked, this authorization is valid for 1 year from the signature date above, or for the following time period:

Beginning Date: _____. Ending Date: _____.